

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 20 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

161113

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4367**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3219 1/2 Franklin Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **2 1/2 yrs**
years, months or days)

3. (a) PRINT FULL NAME **Mary Allen Amey**
(b) If veteran, _____ 3. (c) Social Security No. _____
name war _____

4. Sex **Female** 5. Color or race **Cauc** 6. (a) Single, widowed, married **Married**
6. (b) Name of husband or wife **Jessie** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **Aug 16th 1898**
(Month) (Day) (Year)

8. AGE: Years **45** Months **8** Days **21** If less than one day
hr. _____ min. _____

9. Birthplace **Nelma Ark 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Robert Johnson**
13. Birthplace **Lawrence Ky**
(City, town, or county) (State or foreign country)
14. Maiden name **Adeline Kelley**
15. Birthplace **Marion Ark 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jessie Amey**
(b) Address **3219 1/2 Franklin Ave**

17. (a) **Burial** (b) Date thereof **5-13-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J. R. Randle**
(b) Address **3133 Beech Ave**

19. (a) **MAY 11 1944** (b) **J. F. Baerick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **17**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3219 1/2 Franklin Ave**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **meup**
year **1944** hour **12** minute **45** M.

21. I hereby certify that I attended the deceased from **January 17**, 19**44**, to **February 1**, 19**44**
that I last saw him alive on **April 1**, 19**44**
and that death occurred on the date and hour stated above.
Immediate cause of death **Cerebral Hemorrhage**

Due to **Prob. Hypertension**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature **William H. M... M.D.** (M. D. or other) _____
Address **3507 Franklin Ave** Date signed **May 18, 1944**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed _____

Licensed Embalmer No. 2698

P. O. Address 2769 Chouteau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.